114.5 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.5 CMR 12.00 NURSING FACILITY USER FEES

12.01 General Provisions

(1) Scope and Purpose. 114.5 CMR 12.00 governs the collection of nursing facility user fees.

(2) Authority: 114.5 CMR 12.00 is adopted pursuant to M.G.L. c. 118G, §25.

(3) Effective Date. 114.5 CMR 12.00 is effective on September 1, 2009.

12.02 Definitions

Meaning of Terms: As used in 114.5 CMR 12.00, unless the context otherwise requires, terms have the following meanings:

Assessment. The total payment due each quarter for each non-Medicare Patient Day, as set forth in 114.5 CMR 12.00.

CMS. The federal Centers for Medicare and Medicaid Services.

Continuing Care Retirement Community (CCRC): A community that furnishes board and lodging together with nursing services, medical services or other health related services, regardless of whether or not the lodging and services are provided at the same location, to individuals, other than those related by consanguinity or affinity to the person furnishing such care, pursuant to a contract effective for the life of the individual or for a period in excess of one year, and that has filed disclosure information with the Massachusetts Executive Office of Elder Affairs pursuant to M.G.L. c. 93 § 76(e). Licensed nursing facility beds not under the direct control of the board of the CCRC are not considered part of the CCRC.

Department. The Massachusetts Department of Public Health.

Division. The Division of Health Care Finance and Policy established under M.G.L. c. 118G or its designated agent.

Facility. A nursing facility licensed by the Department of Public Health under M.G.L. c. 111, § 71, including nursing or convalescent homes, an infirmary maintained in a town, a charitable home for the aged, and transitional care units.

Fiscal Year (FY). The Commonwealth Fiscal Year from July 1 through June 30.

MassHealth. The Medical Assistance program administered by the Division of Medical Assistance to furnish and pay for medical services pursuant to M.G.L. c. 118E and Title XIX and XXI of the Social Security Act, and waivers thereof.

Medicaid Bed Day: A day of care for which the primary payer is either MassHealth or a non-Massachusetts Medicaid program.

Medicare. The medical insurance program established by Title XVIII of the Social Security Act.

Medicare Patient Day. A Medicare Part A Patient Day insured under either an indemnity fee-for-service arrangement or a Medicare health maintenance organization.

Patient Day. A day of care provided to an individual patient by a Facility. A Patient Day includes the date of admission and the date of admission and discharge if both occur on the same day. A Patient Day does not include the date of discharge or days of service to Residential Care residents. Hospice days should be counted based on the payer of room and board services. A Patient Day includes any day that has not yet been reimbursed by the insurer. PACE and MassHealth SCO days are considered Massachusetts Medicaid days.

Residential Care. The minimum basic care and services and protective supervision required by the Department of Public Health in accordance with 105 CMR 150.000 for residents who do not routinely require nursing or other medically-related services.

Residential Care Facility (RCF): A nursing facility licensed by the Department of Public Health in which more than 50% of the licensed beds are designated as Residential Care (Level IV) beds.

12.03 Nursing Facility Classes

(1) Nursing Facility user fee payment liability will vary by facility class. The four classes of Nursing Facilities for purposes of this regulation shall be defined as follows:

Class I: All facilities that do not qualify for classes II – IV.
Class II: Non-profit continuing care retirement communities and residential care facilities, as designated in a waiver under 42 CFR 433.68(e) that is approved by the Centers for Medicare and Medicaid Services.
Class III: Non-profit nursing facilities that participate in the Medicaid program and that provided more than 66,000 annual Medicaid bed days in FY2005.
Class IV: Facilities that:

(a) have 100 or fewer licensed beds; and
(b) were established and licensed in Massachusetts prior to the enactment of the Health Insurance for the Aged Act, Pub. L. 89-97, Title I, 79 Stat. 290, and the Medicaid Act, Pub. L. 89-97, Title I, §121(a), 79 Stat. 343, on July 30, 1965; and
(c) are not participating in either of the Medicare or Medicaid programs, except as provided in (d) below.
(d) In addition, Class IV includes homes located in Essex, Middlesex, and Suffolk counties that meet criteria (a) and (b) above but that do participate in the Medicaid program.

(2) Facilities not included in the Division's approved waiver under 42 CFR 433.68(e) or new facilities that come into operation after June 6, 2006 will be considered Class I facilities until the Division determines eligibility and compliance under federal waiver requirements. Facilities that undergo a change in status that alters their class eligibility subsequent to the effective date of this regulation will remain in their original class until the Division determines eligibility and compliance under federal waiver requirements.

12.04 Calculation of User Fee

(1) The Division will calculate the per diem User Fee annually. The user fee will be calculated by determining an amount (X), such that

(a) The number of expected days in Class I facilities times (X), plus

(b) The number of expected days in Class II and Class III facilities times (0.1) times (X), equals

(c) The total amount of revenue to be collected as determined by the General Court for each Fiscal Year.

This estimate will be based on Patient Day data from the most recent year for which data is available.

Effective September 1, 2009, the User Fee will be applied as follows:

Facility Class	**User Fee Effective 9/1/09**
Class I	$19.17
Class II	$1.92
Class III	$1.92
Class IV	$0.00

(2) If the Division determines that the total amount of User Fee revenue will be significantly different than estimated, it may recalculate the User Fee. The Division may change the User Fee prospectively by administrative bulletin to reflect such changes based on the methodology described above.

12.05 Payment of User Fee

(1) Quarterly Assessment. Each Facility shall pay a quarterly assessment to the Division. Each Facility shall determine the amount of the assessment owed for each quarter by multiplying (1) its total non-Medicare Patient Days by (2) the per diem User Fee established by the Division.

(2) User Fee Form. Each Facility must submit its Quarterly Assessment on a form prepared by the Division. Each Facility must report quarterly its total Patient Days by insurer and its non-Medicare Patient Days. The failure to receive the form shall not stay the obligation to remit the User Fee. This reporting requirement applies to facilities in Class IV that have no user fee payment liability.

(3) Due Date. Assessment payments and the User Fee form are due 30 days following the end of each calendar quarter. The assessment and the user fee form are due according to the following schedule:

Assessment period	Payment and Form Due Date
July 1 – September 30	November 1
October 1– December 31	February 1
January 1 – March 31	May 1
April 1 – June 30	August 1

In the event of a closure, a Facility must pay the user fee within thirty (30) days of the date of closure.

(4) Administration. The Division will inform facilities by administrative bulletin of the procedures for the payment and collection of the User Fee. The Division will update these procedures from time to time by administrative bulletin.

(5) Interest and Late Fees. The Division may assess interest and late fees on unpaid liabilities. If a Facility fails to remit an assessment due, the Division will assess interest at up to 1.5% per month on the outstanding balance. The Division will calculate the interest from the due date. The Division may also impose a late fee of up to 5% per month of the outstanding balance.

(6) Assessment Revenue. The total amount of assessments collected, any federal financial participation generated from the payments to Facilities based on the collected assessments, penalties, and any interest earned shall be credited to the Health Care Security Trust Funds established by M.G.L. c. 29D.

(7) Enforcement Provisions.

(a) In addition to interest and late fees imposed pursuant to 114.5 CMR 12.04(5), the Division may notify the Department if a Facility fails to pay a required assessment. Under the statute, the Department shall revoke licensure of a Facility that fails to pay a delinquent assessment.

(b) For unpaid liabilities greater than 120 days overdue, the Division may intercept payments from other state agencies in accordance with the regulations of the Office of the State Comptroller, 815 CMR 9.00: Debt Collection.

12.06 Reporting Requirements

(1) General. Each Facility shall file or make available information which is required or which the Division deems reasonably necessary for calculating and collecting the user fee.

(2) Required Reports. Each Facility must file required reports and forms with the Division. Each Facility must submit any additional documentation requested by the Division to verify the accuracy of the data submitted.

(3) Audit. The Division may inspect and copy the records of a Facility for purposes of auditing its calculation of the assessment.

(a) If the Division determines that a Facility has either overpaid or underpaid the assessment, it shall notify the Facility of the amount due or refund the overpayment.

(b) The Division may offset overpayments against amounts due the Division for the assessment.

(c) If a Facility is aggrieved by a decision of the Division as to the amount due, it may file an appeal to the Division of Administrative Law Appeals within 60 days of the date of the notice of underpayment or the date the notice is received, whichever is later. The filing of an appeal will not toll the collection of interest and penalties.

(4) Penalties. The Division may impose a per diem penalty of $100 per day if a Facility fails to submit required reports or furnish other documentation requested under this regulation by the dates specified in 114.6 CMR 12.04(3) or as specified in the Division's Administrative Bulletins.

12.07 Other Provisions

(1) Severability. The provisions of 114.5 CMR 12.00 are severable. If any provision or the application of any provision is held to be invalid or unconstitutional, and such invalidity shall not be construed to affect the validity or constitutionality of any remaining provisions of 114.5 CMR 12.00 or the application of such provisions.

(2) Administrative Information Bulletins. The Division may issue administrative information bulletins to clarify policies, update administrative requirements and specify information and documentation necessary to implement 114.5 CMR 12.00.

REGULATORY AUTHORITY

114.5 CMR 12.00 M.G.L. c. 118G.